

# EQUIPMENT REQUEST NAVMED 6700/12

1. Medical or Dental Facility (Name and City):	UIC:	ECN:
Branch Medical/Dental Clinic:	Branch UIC:	Date:
Requesting Dept/Div:	Dept/Div Code:	Command Priority:
Standard Nomenclature:		Equip Type Code:

**2. Item Description:** (Use additional sheets if required.)

a. General description including **ALL** components and accessories.) (Attach manufacturer's literature and quotation.)

**Suggested Mfr.** \_\_\_\_\_ **Model No.** \_\_\_\_\_ **Acquisition Cost \$** \_\_\_\_\_  
**(Not guaranteed to be purchased)** (Cost includes accessories, installation and facility modification.)

b. Essential Characteristics: (Detailed, nontechnical, functional description, including accessories and options, of the minimum features and capabilities required to enable completion of intended task. Do not use manufacturer specific terms, model numbers, catalog numbers or proprietary information. **Description must be generic, not manufacturer specific**).

c. General design features required to meet existing installation limitations:

- (1) Maximum dimensions (in inches): Height \_\_\_\_\_ Width \_\_\_\_\_ Depth \_\_\_\_\_
- (2) Weight not to exceed (in pounds): \_\_\_\_\_
- (3) Electrical voltage available: VAC \_\_\_\_\_ Hz \_\_\_\_\_ Amp \_\_\_\_\_ Phase \_\_\_\_\_
- (4) Mounting requirements (ie. Seismic, fastened to deck, overhead or bulkhead, etc.): \_\_\_\_\_
- (5) Utilities required: Water \_\_ Drain \_\_ Heat Dissipation \_\_ Temperature Regulation \_\_ Gases \_\_
- (6) Other unique requirements, not previously mentioned (ie. surge protection, security requirements (locks, cabinets, doors, etc.): \_\_\_\_\_

(7) Is the ability of the manufacturer to provide local maintenance and support critical? If yes, describe the support required, acceptable response time and any factors an offeror should be made aware of (e.g. limited access to base, citizenship requirements, etc.)

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COMMAND: \_\_\_\_\_ UIC: \_\_\_\_\_ ECN: \_\_\_\_\_

**3. JUSTIFICATION.** (Use additional sheet(s) to answer. Indicate command name and ECN each page. For timely consideration, ensure your submission contains all information requested.)

**a. Cost/Benefit Analysis** (Reference DoD Instruction 7041.3, Economic Analysis for Decision Making). The economic analysis report should begin with a summary of the analysis (based on the benefits and costs of the alternatives), and an interpretation of the results (to include a recommendation of the preferred alternative). The actual decision is based on qualitative as well as quantitative factors. The results of the economic analysis, including all calculations and sources of data, must be documented down to the most basic inputs to provide an audible and stand-alone document.

(1) The purpose of the economic analysis is to give the decision makers (NMLC, BUMED, & SG Specialty Leaders) insight into economic factors bearing on accomplishing the objectives. Therefore, it is important to identify factors, such as cost and performance risks and drivers, which can be used to establish and defend priorities and resource allocations. Your economic analysis of investment alternatives must include the five elements listed in (2) – (6).

(2) **OBJECTIVE:** Clearly define what the requested equipment will be used for and what you plan to accomplish by having this equipment.

(3) **ASSUMPTIONS:** Base economic analysis on facts and data when possible. Since economic analysis deals with costs and benefits occurring in the future, assumptions must be made to account for uncertainties. (At a minimum, provide 2 years workload history (from CEIS by CPT code for inpatient and outpatient) and 2 years of projected workload. Rational for increases must be included).

(4) **ALTERNATIVES:** Feasible ways of satisfying the objective **must be** documented and discussed. (i.e., cost to refurbish old equipment, CHAMPUS, Supplemental Care, use of neighboring MTF's equipment, similar equipment in your facility that you might use, etc.)

(5) **COSTS AND BENEFITS:** List the costs and benefits associated with each alternative. (i.e., include an analysis addressing costs per procedure under each alternative.)

(6) **Projected five-year life cycle for new equipment which should include at a minimum equipment cost, training, maintenance, supplies, etc.**

(7) **COMPARISON OF ALTERNATIVES:** Compare the costs and benefits of each alternative and rank them according to net present value. **You must evaluate and document leasing options.**

**b. How is the function of the item currently being accomplished?**

**c. Provide information on current staff, by specialty, that is available to use the equipment and what, if any, additional staffing will be required.**

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### **3. JUSTIFICATION (cont.)**

**d. Mission impact if not funded in the fiscal year requested.**

**e. Will requested item be used in conjunction with other equipment within the entire facility (existing or proposed)?**

**If Yes, Explain.**

**f. Provide information on similar equipment that is currently available at the facility and the usage of that equipment (existing or proposed) even if it is in another department of the hospital.**

**g. Is operator training required? (Describe)**

**h. Is this requirement a result of a Business Process Reengineering initiative? If yes, discuss results and recommendations.**

**i. Additional information as needed.**

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4. Equipment is New \_\_\_ Replacement \_\_\_ Upgrade \_\_\_ If replacement/upgrade, complete the following:

a. Item being replaced/upgraded: Nomenclature \_\_\_\_\_ Manufacturer \_\_\_\_\_

Model No. \_\_\_\_\_ Serial No. \_\_\_\_\_ DPAS Bar Code No. \_\_\_\_\_

b. Proposed disposition of replaced equipment; Dispose \_\_\_ Excess to command \_\_\_ Retain \_\_\_ Why retain?

\_\_\_\_\_

(NMLC reserves the right to trade-in any equipment marked dispose or excess to command)

5. Who is the Department's Clinical POC:

\_\_\_\_\_

Typed name and commercial Phone No.

Department Head Signature

\_\_\_\_\_

Typed name/signature of DH Commercial Phone No./Date

6. Any computer system interfaces required (i.e. CHCS, LIMS, DIN-PACS)? Yes \_\_\_ No \_\_\_

If yes explain \_\_\_\_\_

\_\_\_\_\_  
Typed name/signature of Head, MID Date

7. Facilities Manager:

a. Is facility modification required (i.e., additional electrical support; plumbing (water, steam, drainage); emergency power; gas (air, O<sub>2</sub>, vacuum); exhaust; additional heating, A/C, ventilation; radiation shielding)?

Yes \_\_\_ No \_\_\_ (If yes, estimated cost.) \$ \_\_\_\_\_

b. Is installation required? Yes \_\_\_ No \_\_\_ (If yes, estimated cost.) \$ \_\_\_\_\_

c. Are M2/R2 dollars required for installation? Yes \_\_\_ No \_\_\_ (If yes, are they available? Yes \_\_\_ No \_\_\_)

d. Are there any environmental impacts (increase or decrease) due to the proposed request (i.e., hazardous waste generated, noise levels, radiation, ozone depleting substances, etc.)?

e. Additional considerations not previously mentioned. (Use additional sheet if required.)

\_\_\_\_\_  
Typed name/signature of Facilities Manager

\_\_\_\_\_  
Phone No.

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COMMAND: \_\_\_\_\_ UIC: \_\_\_\_\_ ECN: \_\_\_\_\_

**8. Biomedical Engineering Representative:**

a. Maintenance/repairs will be provided by: \_\_\_\_\_ In-house BMET. (Is additional training required?)

Yes \_\_\_\_\_ No \_\_\_\_\_ Commercial Contract \_\_\_\_\_ (Estimated cost) \$ \_\_\_\_\_

b. To be completed for replaced/upgraded equip: Month/Yr installed \_\_\_\_\_ Life expectancy \_\_\_\_\_ Condition Code \_\_\_\_\_

Total Man-hours expended: Preventive maintenance \_\_\_\_\_ Corrective maintenance \_\_\_\_\_

Cost of repair parts and service to date. \$ \_\_\_\_\_ Cost of maintenance services to date. \$ \_\_\_\_\_

Is maintenance record (BIOFACS maintenance record) available? Yes \_\_\_\_\_ No \_\_\_\_\_

If No, why not?

\_\_\_\_\_

Typed name/signature of Biomedical Engineering Representative

Phone No. \_\_\_\_\_

**9. Are there any Safety requirements? Yes \_\_\_\_\_ No \_\_\_\_\_**  
If yes, attach addendum.

\_\_\_\_\_  
Typed name/signature of Safety Officer Date

**10. Reviewed by Head, Materials Management Department**

\_\_\_\_\_  
Typed name/signature  
Date

**11. Type of funding: OP \_\_\_\_\_ FIP \_\_\_\_\_ IH \_\_\_\_\_ Lease \_\_\_\_\_**  
Initial Outfitting \_\_\_\_\_

\_\_\_\_\_  
Typed name/signature of Comptroller Date

**12. Reviewed by Equipment Program Review Committee**

\_\_\_\_\_  
Typed name/signature of Chairman  
Date

**13. Attachments:**

Facilities Survey \_\_\_\_\_ CBA \_\_\_\_\_ Manufacturer's Quote \_\_\_\_\_  
Manufacturer's Literature \_\_\_\_\_ Other \_\_\_\_\_

\_\_\_\_\_  
Typed name/signature of Equipment Manager Date

**14. Commanding Officer**

\_\_\_\_\_  
Typed name/signature  
Date

INSTRUCTIONS FOR PREPARING  
EQUIPMENT REQUEST (NAVMED  
6700/12)

**BLOCK 1:**

**Medical or Dental Facility (Name and City):** Provide complete command name and city for the appropriate facility. Do not use local names. This is not where a branch clinic is indicated. This is the hospital or dental command that has the responsibility of the branch clinic.

**UIC (Unit Identification Code):** Provide UIC for the Medical or Dental Facility.

**ECN (Equipment Control Number):** Provide unique six digit number assigned for each individual item. Sometimes these numbers are assigned by the Equipment Manager. See Section 3-5, 1d of this manual for assigning ECNs.

**Branch Medical/Dental Clinic:** Provide the name, base and city for the branch medical or dental clinic for which the equipment request is ultimately for. Do not use local names. *LEAVE BLANK IF REQUEST IS NOT FOR A BRANCH MEDICAL OR DENTAL CLINIC.*

**Branch UIC:** Provide the UIC for the branch medical or dental clinic indicated in the previous block. *LEAVE BLANK IF REQUEST IS NOT FOR A BRANCH MEDICAL OR DENTAL CLINIC.*

**Date:** Use current date.

**Requesting Dept/Div:** Provide name of department and division requesting the equipment.

**Dept/Div Code:** *TO BE COMPLETED BY THE EQUIPMENT MANAGER.* Provide the appropriate department or division code from Annex 11.

**Command Priority:** *TO BE COMPLETED BY THE EQUIPMENT MANAGER AFTER THE EQUIPMENT PROGRAM REVIEW COMMITTEE*

*MEETS.* Provide the command's priority for the POM or Budget year budget submission whichever is appropriate.

**Standard Nomenclature:** *TO BE COMPLETED BY THE EQUIPMENT MANAGER.* Provide the standard nomenclature from Annex 25. If the request is for an "upgrade" use the standard nomenclature and add "(UP-GRADE)" at the end. If the request is for a "system" use the standard nomenclature and add "SYS" at the end. Equip Type Code: *TO BE COMPLETED BY THE EQUIPMENT MANAGER.* Use the appropriate Equipment Type Code provided in Annex 25.

**BLOCK 2:**

**Item Description:**

a. Provide a general description and characteristics including ALL components and accessories. For planning purposes, a suggested manufacturer, model number, and total acquisition cost are to be provided. *DO NOT USE LOCAL DISTRIBUTORS NAME OR MODEL NUMBER.* The total acquisition cost must include the cost of the requested item plus the costs of all components, accessories, installation and facility modification appropriate for OP funding.

b. Provide generic detailed, nontechnical, functional description. (Not required for POM submission)

c. Self-explanatory (Not required for POM submission.)

**BLOCK 3:**

**Justification:**

a. Instructions on form. Provide a Cost/Benefit Analysis to include the objective, assumptions, alternatives, costs and benefits for each alternative,

comparison of the alternatives and 5-year life cycle. **DO NOT TRY TO FIT THE INFORMATION ON THIS FORM. USE ADDITIONAL PAPER.** (Not required for POM submission)

**b.** Provide statement on how the function is currently be accomplished.

**c.** Provide information on current staffing and additional staffing (if required).

**d.** Provide information on the impact if the item is not funded in the FY requested (CHAMPUS cost, Supplemental Care cost, leasing required). (Not required for POM submission.)

**e.** Provide information on any existing or programmed equipment that the requested item will be used with. (Not required for POM submission.)

**f.** Provide information on similar equipment that is currently available at the facility (even in other departments) and the usage of that equipment. *ASSISTANCE FROM THE EQUIPMENT MANAGER MAY BE REQUIRED TO COMPLETE THIS INFORMATION.* (Not required for POM submission.)

**g.** Explain if any operator training is required either inhouse or at manufacturer's site.

**h.** Self-explanatory.

**i.** Self-explanatory.

**BLOCK 4:** Indicate if the equipment is new; is a replacement; or is upgrading current equipment on hand.

**a.** To be completed if the requested item is replacing or upgrading a unit currently in use. Information must match DPAS.

**b.** To be completed if the requested item is replacing a unit currently in use. If the current unit is going to be retained

indicate why it will be retained.

**BLOCK 5:**

**Requesting Department Head:**

Provide the name and commercial phone number of the person most familiar with the requirement of the requested equipment. Provide typed name, rank/grade, phone number, and signature of the requesting department head.

**BLOCK 6:**

*TO BE COMPLETED BY THE HEAD, MID.* Indicate if any computer system interfaces are required and explain what they will be.

**BLOCK 7:**

Facilities Manager: *TO BE COMPLETED BY THE ASSIGNED CIVIL ENGINEER OR PUBLIC WORKS OFFICER.*

**BLOCK 8:**

Biomedical Engineering Representative: *TO BE COMPLETED BY THE BIOMEDICAL EQUIPMENT REPRESENTATIVE.* If the item is a nonmedical request, indicate "N/A" in the signature area. Include phone numbers. (Not required for POM submission.)

**BLOCK 9:**

Are there any Safety requirements? *TO BE COMPLETED BY THE SAFETY OFFICER.* If there are safety requirements, please provide an addendum indicating what requirements there are and if the requested item will meet those requirements.

**BLOCK 10:**

Reviewed by the Head, Materials Management Department. Provide the

typed name, date, and signature of the Head, Materials Management Department.

**BLOCK 11:**

Type of funding: Indicate the type of funding for which the equipment request was completed. Is it for OP, FIP, IT, IH, Initial Outfitting (MILCON project), Lease? Provide the typed name, date, and signature of the Comptroller.

**BLOCK 12:**

Reviewed by Equipment Program Review Committee. Provide the typed name, date, and signature of the Chairman, EPRC.

**BLOCK 13:**

Indicate what attachments are included and provide the typed name, date and signature of the Equipment Manager.

**BLOCK 14:** Commanding Officer. Provide the typed name, date, and signature of the Commanding Officer.